Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTERGRATIVE HEALTH AND MEDICAL
PO BOX 9973
THE WOODLANDS TX 77387

Respondent Name
ACIG INSURANCE CO

Carrier's Austin Representative Box
Box Number: 47

MFDR Tracking Number
M4-13-2961-01

MFDR Date Received
JULY 9, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting MDR solution regarding attached 07-09-2012 claim. The initial claim was faxed to a verified carrier fax number with the 95th day timely file rule as indicated via attached fax confirmation. No EOB and/or EOR was received as required by rule. The 'Request for Reconsideration' was then sent in a timely manner via same verified carrier fax number. We received an EOB and/or EOR denying the claim due to 'Time Limit for Filing Claim/Bill has Expired'. Pleases note, the claim was received by the carrier within the 95th day timely file rule. No required EOB and/or EOR was issued. The 'Request for Reconsideration' was received by the carrier within the required time parameters. The carrier ignored the proof of receipt that was attached and denied the claim. I would ask as this time that the proof of receipt attached be verified and that the carrier issue payment as soon as possible."

Amount in Dispute: $6,095.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9, 2012	CPT Codes 99202, 95861, 95934-50, 95903-59, 95904-59	$6,095.00	$1,479.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.

4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – Time limit for filing claim/bill has expired.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds documentation, in the form of a fax confirmation sheet dated October 11, 2012 to support that a medical bill was submitted on the 95th day from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.
2. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has not forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute and is due $1,479.65 as listed below:
   - CPT Code 99202 (54.86 ÷ 34.0376) x $72.68 = $117.14
   - CPT Code 95861 (54.86 ÷ 34.0376) x $140.04 = $225.71
   - CPT Code 95934-50 (54.86 ÷ 34.0376) x $61.80 = $99.61
   - CPT Code 95903-59 (54.86 ÷ 34.0376) x 75.41 x 4 units = $486.17
   - CPT Code 95904-59 (54.86 ÷ 34.0376) x $56.98 x 6 units = $551.02

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,479.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,479.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 17, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.